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## SELECTION OF PATIENTS FOR SURGERY

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It is said, "Strength lies in unity." By this rule Rhode Island has a chief advantage, for its very smallness gives unity and therefore strength. We in Massachusetts, who were your forebears, now look with jaundiced eye upon our predecessors, who, beset by evil spirits and black magic, drove forth your predecessors from our doors. That you should now welcome some of us to your very bosom further betokens the advanced stage of your civilization, as well as your appreciation of the greatest of books, the Bible. We come to you repentant of our sins and grateful for your invitation.

Consider with me this evening the selection of patients for surgical treatment. Offhand this may seem a hackneyed topic, yet we believe there are elements of interest for discussion to all who practice the healing art. The surgeon may appear to have a chief interest, since on his shoulders will surely fall any criticisms should unfortunate sequelae develop. But what of the physician? He is the chief source of supply for the surgeon. He must recognize the dangers of any therapy he recommends, and since he is usually the one first consulted, the therapy he institutes and the drugs he administers may play a major rôle in the final outcome. Should the physician delay in a case of acute appendicitis, he knows the calamity which may befall. But is it any greater calamity if a patient with a renal stone impacted in the ureter is turned away from surgery by a physician? To be sure, death may not come for several years until a blocked kidney and mounting renal sepsis have robbed the patient of any hope of relief; yet the responsibility rests securely with the physician. Thus any discussion in this field affects us all. We present this

matter with a great feeling of humility, having made many mistakes ourselves. Failure to carry out a barium enema examination early in the course of study of a patient with silent carcinoma of the sigmoid without obstruction has delayed surgery too long to give relief. Choice of the wrong anesthetic has robbed others of a meager chance at life.

Two important factors continue to change our considerations of the matter under discussion as the years pass by. First, we must hurdle the shift in judgment which arose when anesthesia was introduced as to what disorders and which patients are suitable for surgical therapy. Preceding the days of anesthesia only *emergency* surgery was practiced. This was largely the care of injury, superficial infection, and tumors. The knife was a dreaded and painful weapon, and its possible beneficence could not be visualized through the screen of terror which its use provoked. But with the blessing of anesthesia this objection fell aside. It is true that the darkest days of medicine followed the advent of anesthesia until the relation of bacteria to disease was understood and asepsis was established. A recent study of this period of medical history shows that, whereas in the Massachusetts General Hospital in 1845, the year before ether was developed, only fifty-seven operations were performed, two hundred ninety-three operations were carried out in 1855. The reading of the records of that period is not pleasant. Sepsis of all kinds dogged the footsteps of the surgeon, and one can visualize in case reports the incisive words of the great Velpeau, "A pin prick is a door open to death which widens before the slightest use of the bistoury." Only when asepsis robbed surgery of this terror was *elective* surgery possible. Today elective surgery constitutes the major portion of this form of mechanical treatment. Unfortunately, all physicians do not fully appreciate the distinction between emergency and elective surgery. Surgery is occasionally offered as

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a necessity when there is more than a reasonable doubt that the complaint and its cause are compatible with a happy and useful existence.

The mother who presents her child to a doctor with obvious acute appendicitis is a typical case of emergency surgery. Here the doctor's responsibility is plain. The child must have surgical therapy at once. Should the mother refuse, the physician should persuade the parent to see another doctor and should not rest easy until the surgeon has been selected and the operation is under way. A typical example of elective surgery is cholelithiasis. Many persons in whom gallstones are noted come to autopsy from other causes and yet the clinical history presented no complaints which could, by the longest stretch of the imagination, be attributed to the gallstones. We are not justified in telling patients in whom gallstones are proved by accurate examinations that surgical treatment must be carried out. We cannot honestly tell such patients they will surely die from such stones unless the stones are removed. We can say under certain circumstances that the chances are considerable that stones in the gallbladder may pass into the common duct; that surgery carries a far higher mortality rate when the patient is jaundiced than when he is not; that in those in early adult life the recurring bouts of indigestion during the next twenty years will eventually bring them to a surgeon; and that, therefore, the gallbladder should be removed. But in this type of disease the patient must make the final decision, and the surgeon or physician has no justification for insisting on surgical treatment. As extreme examples of this, I have two patients over ninety with typical biliary histories and findings. Both have been jaundiced. Both showed gross cardiac irregularities. In one case the physician insisted upon surgery. Neither have had surgery, yet both have had a comfortable winter. These cases represent a common fragment of the field of elective surgery in the aged.

A second reason for considering our topic of the selection of patients for surgical treatment is wrapped up in the extraordinary increase in longevity. A baby born in the United States in 1850 had a life expectancy of about forty years. A baby born today can look forward to approximately sixty years of life. At the same time there has been a decrease in the birth rate, and these two factors have operated to produce a tremendous shift in the

age composition of the population. In 1850 persons over sixty-five comprised 2.6 per cent of the population. Today they constitute 6.4 per cent, and in 1980 they should have reached 14.4 per cent. In other words, about 8.4 million of our present population of 132 million are sixty-five or over. Forty years hence they will constitute 22 million out of a population of 153 million.

This increase in the life span brings sharply to our attention the importance of medical treatment for the aged. Geriatric surgery is to be perhaps a very large part of the work of the surgeon of the future. Already the surgical literature abounds with studies of this important phase of medical practice, and the medical student of today must envisage an entirely different point of view than that taught to most of us twenty to thirty years ago. He must begin to appreciate that a conservative attitude based merely on the addition of years may rob persons of much comfort and happiness. He must learn to appraise the patient irrespective of his years. All of us unconsciously do this, and all of us recall tough old people whose risk is less than that of many fat, sleek, sedentary folk whose ownership of an automobile has not only wasted their lower extremities but so reduced their capacity for effort that their circulatory response has become seriously impaired. Lacking the physiological stimulation of effort with its resultant appetite and clear thinking, they seek a return to their earlier vigor in increasing resort to alcoholic stimuli and thus sink deeper into their mounting obesity, shiny skin, and false psychological security. Whoever saw a good life insurance risk over fifty whose weight approached two hundred pounds? No, it is the tough, thin, scraggly ones who hang on like tough oaks, nourished well even by a thin soil and diet which keeps them scrambling to maintain their vigor. In the words of James Paget, "Years, indeed, taken alone are a very fallacious mode of reckoning age: it is not the time, but the quantity of a man's past life that we have to reckon. \* \* The old people that are thin and dry and tough, clear-voiced and bright-eyed, with good stomachs and strong wills, muscular and active, are not bad; they bear all but the largest operations very well. But very bad are they, who, looking somewhat like these, are feeble and soft-skinned with little pulses, bad appetites, and weak digestive power: so that they cannot, in an emergency, be well nourished."

These introductory remarks concerning elective surgery and surgery in the aged will, I hope, emphasize our topic, "The selection of patients for surgery." Our title might well have been "Pre-operative study" or "Improving the surgical risk" only that the physicians here would have then thought, "This is just another surgical paper which we must sit through!" The truth is I wish the physician who constitutes the backlog and balance of American medicine to see his share in these problems. Surgery is a dangerous means of therapy. No patient should be put to this risk unless there is adequate cause. And when the risk must be taken, every safeguard must be set up in advance of the ordeal. Only with this attitude can modern medicine and surgery progress. And it is not only a question for the surgeon, for the physician who advises surgical therapy must be equally able to appraise the risk before he instills unwarranted hope in his patient and the family. This is a responsibility we must shoulder jointly.

Any discussion of the preoperative study and care of the patient makes it very clear that the chief considerations, which have to do with the patient before he is submitted to a surgical ordeal, are of a physiological nature. To be sure there are two great groups of surgical patients, those who are *poor risks* and those who are *good risks*; but just because a patient is a good risk is no reason for neglecting the proper preoperative treatment which will render him a still better risk. We can perhaps do very little in the way of lessening the risk of the emergency case as opposed to a case in which the operation is one of election, but even in the emergency case some benefit may accrue from a proper evaluation of the patient's physiological status as contrasted with his anatomical status. The ideal considerations surrounding a satisfactory surgical risk permit a patient to come to operation *with the tissues adequately supplied with fluid, the food reserves in their normal state, the metabolism adjusted as perfectly as it may be, the intestines working normally, the circulation at its optimum level, and a nervous system as undisturbed and peaceful as in daily life.*

Examples of the dangers attendant upon surgery in patients who are desiccated or whose food reserves are impaired are frequently seen. Consider a patient with chronic obstruction at the pylorus due to long-standing ulcer with cicatrization, or a

patient with obstruction at the ileocecal valve from cancer of the cecum. If the vomiting has occurred over a long period of time, the relations of plasma to cell volume in the blood may be seriously changed, the urine concentration is high, alkalosis appears from loss of chlorides, and even the relation of tissue protein to plasma protein becomes dangerously altered. All these untoward changes may be modified or reversed by proper preoperative therapy, and the risk of surgery may be tremendously reduced. When we consider surgical intervention in individuals with an unsuspected high basal metabolic rate determination we court the disaster of a post-operative thyroid "storm." This thyrotoxic condition may remain unsuspected until the patient reaches the operating room anesthetized. A glance at the alarming rise in pulse rate and pulse pressure as seen on the anesthesia chart will certify to the diagnosis. It is a hard task for the surgeon to be prepared with a full team at the table and then have to call off the surgical procedure. But this must be the attitude of the conscientious surgeon. There is no place in American medicine today for the person who will take any unnecessary risks with the lives of others. And when we consider surgery in those with an impaired circulation we must expect pulmonary disabilities, embolism, and the other sequelae to surgery which depend in part upon this circulatory failure. Here is a special field for the assistance of our internist colleagues in our great responsibility. Much can be done before the ordeal to diminish the risk in such cases.

Only thirty years ago it was customary to withhold water and food for at least a day before the surgical ordeal and also to purge the patient deliberately. This preparation was based on the assumption that postoperative vomiting and distention were less likely to occur if the intestines were empty. At that time the dangers of dehydration and starvation and the actual condition both of the innervation of the gut wall and of the intestinal contents after purgation were not understood. The importance of a normal level of the constituents in the blood serum was unknown, and satisfactory tests for blood volume, circulatory efficiency, the basal metabolic rate, and the function of the autonomic nervous system were not established.

It is not our purpose to enter into a detailed discussion of all these matters, but it is wise to emphasize that a previously normal patient who suddenly experiences an accident of physical nature, such as rupture of a duodenal ulcer, and who requires immediate surgical therapy without preparation, frequently suffers the minimum of postoperative difficulties. Conversely, it is well recognized that a long period of hospitalization before the surgical operation, particularly if it necessitates bed rest, is undesirable. Also we must recall that certain types of disease present a more serious risk than others. It is recognized that patients with exophthalmic goiter are a grave responsibility, and experience has shown that such patients do better if they are as little disturbed from their daily routine as possible. Thus it is customary to make no special local preparation for them the day before or the morning of the operative ordeal. These examples seem to indicate that the less preparation, the better the result; and they should at once put an end to preoperative preparations which in any way disturb the patient from his routine of living. The fact that a patient with inguinal hernia is a simple, safe risk, and can tolerate with safety enemata, special preparation of the operative field, a shift in diet, and a period of bed rest does not justify an arduous and annoying preparation. There can be little doubt that the sins of commission are just as great in this relation as the sins of omission. This introduction should serve to reemphasize the great natural law we all should follow,—*videlicet*, that nature tends to repair and heal all of the lesions to which man is subject and that the doctor should devote his energies chiefly to assisting nature in her way, and that conversely he should not attempt to do anything arbitrarily or without guidance from nature.

In a presentation of special indications for preoperative and postoperative care it seems wise to divide the material into three major groups, each of which presents certain general problems: (1) infants and children, (2) adults, and (3) the elderly.

(1). In the youngest age group the rapidity of reaction is characteristic and often alarming. One sees explosive response to infection, a greater imbalance with restriction of the usual fluid and food intake, the danger of long hospitalization as regards susceptibility to infection, poor resistance to trauma, the necessity for avoiding pain with dressings, et cetera. In this group attention to cor-

rection of the preoperative imbalance of fluids and blood chemistry has been shown to decrease tremendously the risk of surgery. Even in the face of serious intra-abdominal infection or of intestinal obstruction as with intussusception an hour's delay, if it permits the fluid and chemical relationships to be brought to normal is sometimes of life-saving importance.

(2). With the adult group the surgeon will find his safest field, though the addition of sex life and its profound physical and mental ramifications must be given thorough consideration. But even if this group is, as a rule, safe, it should not give a false sense of security to the physician. Many people have impaired renal or cardiac function in whom no suspicion of trouble has ever arisen, therefore tests for such functions should be a routine part of the selection of patients for surgery. Clinical impressions are after all only impressions and hunches unless they are backed by tests, such as measurements of the vital capacity, the speed of the circulation, and the basal metabolic rate.

(3). The elderly will always demand a longer period of preoperative observation and study than the other groups. In this group the aging process has already affected perhaps several important viscera. The circulatory system in particular must be carefully appraised, and the anesthesia and type of procedure adjusted to its defects. Thrombosis constitutes a major risk in this group, and every attempt must be made to diminish the danger of this occurrence. Digitalization should be considered in any patient over fifty. In spite of the medical dictum that digitalis does not benefit the normal mechanism, there is the clinical experience of many surgeons that digitalis or thyroxin in elderly people seems to assist in avoiding pulmonary complications and other sequelae which, in part, depend upon an inadequate circulation. A long period of rest in bed before surgery inevitably reduces the circulatory rate and the general tone of this important system, and should always be avoided when possible. During the operation special care must be given to the great venous channels, and after the operation every attempt must be made to avoid circulatory congestion, both general and local. Frequent change of position is of assistance, and indeed, is an essential part of the care of aged people. This is best accomplished by limiting such patients to short periods in bed irrespective of the procedure. Where early activity is planned, abdominal wounds should

be closed with many tension sutures, either silk-wormgut or wire, including all layers so that there may be less danger of wound rupture and evisceration. Habits of food and fluid intake and of bowel movements must be carefully appraised and continued without deviation whenever possible. Obviously, the function of the kidneys and the physiological status of the lungs should be measured and every attempt made to rule out and improve secondary pathological entities, such as diabetes and anemia, so frequently present in old people.

This brief recital should emphasize the importance of the preoperative study. It is not the purpose of this paper to enter into a detailed discussion of special preoperative considerations, though I should like to point out that each separate disease suggests special tests and studies. Thus, patients with cardiac, pulmonary, renal, or liver disease require certain studies and the most suitable and careful selection of anesthesia. Patients with anemia, diabetes, malnutrition, dehydration, and obesity need correction of their abnormality before a surgical ordeal. I am anxious only to point out that before surgery each patient must be brought as near as possible to normal by proper remedial methods, and that the procedure and the anesthetic must be carefully considered so that no unnecessary risk is incurred.

Finally, in order to evaluate the factors producing any special complication, the surgeon must review each step in the preoperative preparation as well as each step in the operation. Drugs may play a rôle, and we feel there is ample evidence to justify the suggestion that the use of morphine is often dangerous. Morphine lowers both the rate and amplitude of respiratory excursions. If it is used in large doses and frequently repeated, it may, when added to other factors, be sufficient to encourage pulmonary atelectasis. I hope it will not let me appear cruel or unkind to state that a little postoperative suffering which increases the activity of the patient is far better medicine than inducing comfort through the use of powerful drugs.

I hope this discussion has introduced to you the conscientious attitude of modern medicine. Though the advent of anesthesia is only a little less than a century ago and modern asepsis scarcely fifty years behind us, we have benefited so greatly from increased knowledge in chemistry and physiology that anatomical and pathological considerations now must be judged in relation to these funda-

mental considerations. We appreciate the dangers of dehydration and improper food intake; we can recognize before operation and properly adjust chemical imbalances; and we have many anesthetics at our command to suit each situation.

The tendency of modern medicine is to learn by *our* mistakes, and thus to improve constantly the preoperative risk. End-result studies have provided our generation with a fund of knowledge that must be brought to every patient. Great haste in medicine has done much harm both to the doctor and to the patient, and this applies equally to the preoperative and to the operative phases of surgery. Haste has its place only when blood is spouting from the wound. This is of rare occurrence in civil medicine, and hopefully our times may, though the outlook is none too propitious now, avoid experience in this on the battle fields of Europe. Even in patients with intestinal obstruction, haste is dangerous. With modern suction apparatus (the Abbott-Miller double tube) the upper gut may be easily evacuated whilst the chemical imbalance is restored by proper intravenous therapy. Again in patients with peritonitis, time for adequate study before the ordeal will surely lower the postoperative difficulties. In the first place an accurate diagnosis will be made. But perhaps more important for the surgeon, he will appreciate where to place his incision. Let us examine acute appendicitis with abscess formation, one of the most frequent problems presented to the surgeon. He who makes a hasty diagnosis of appendicitis and, wedded to a single incision, enters the abdomen through a rectus muscle splitting incision will often find himself in a clean peritoneal cavity with an abscessed mass beneath the cecum and in the right lower quadrant. Under such circumstances eighty per cent of surgeons will break through into the abscess, spill bacteria into an up-to-now uninvaded peritoneal cavity, and, if the patient recovers after a stormy convalescence, accept the plaudits of the family for his great skill. How much better and how much more intelligent to have recognized exactly the condition by careful preoperative study and then to have made a flank incision which never would have entered the free peritoneal cavity. Thus he would have followed the pointing finger of Mother Nature who was preparing to discharge the trouble in the flank and his patient would have had an uneventful convalescence. The days of showmanship and simple manual dexterity are happily passed. We all rec-

ognize that it is the period of preoperative study and planning that has brought surgery to its useful and beneficent position today. I am hoping that those of you who are physicians will put your trust more and more in the surgeons of this generation who have had an adequate education in physiology and chemistry as well as anatomy and whose gentle and meticulous technique is aimed at avoiding all forms of injury whether it be chemical or mechanical.

Gentlemen, I come immediately from the bedside of a critically ill patient, suffering from suppurative appendicitis, diffusing peritonitis, complete adynamic ileus, a serious postoperative pneumonia, and jaundice of possible pyelophlebitic origin. He lives today, the eleventh postoperative day because of modern medicine and especially its *chemical* aspects. His fluid balance was easily achieved, but the electrolyte balance and the level of the serum proteins, dangerously threatened by ten days vomiting, are in fair shape only because of frequent blood chemical studies. The level of the sulfapyridine in his blood has been maintained by similar tests. His life thus far and his hope of life from now on are dependent on our chemical knowledge and clinical chemical tests. If such a spectacular case fixes my remarks in your memory, remember also that similar tests will prepare your patient for surgery, will give you positive information as to the risks he is to run and will prevent disasters. I beg of you to become chemically and physiologically minded.

#### RHODE ISLAND HOSPITAL

##### Clinical-Pathologic Conference

##### CASE PRESENTED BY DR. WILFRED PICKLES

This patient, male, aged 66, a plumber, was admitted April 11, 1935, complaining of constipation, borborygmus and colic. About five months before, he began to have flatulence, constipation and abdominal colic with small amounts of bright red blood in the stools which were pencil-like and light in color. The appetite was good but the patient had been afraid to eat fearing that this might aggravate his symptoms. He has lost fifteen pounds in weight during the past five months. There is no icterus.

There is no history of familial disease. The patient has been married twelve or fourteen years. The wife has diabetes. There are no children and no miscarriages. The past history was negative except for rheumatism thirty years ago.

Physical examination showed a well developed and nourished man lying in bed in no apparent distress. Teeth were absent. There was a soft systolic murmur at the cardiac apex, the blood pressure was 130/68. The abdomen was much distended and tympanitic, with dullness in the flanks, no visible peristalsis, borborygmus heard, pressure on the abdomen gives relief to the patient. Rectal examination caused pain and was therefore unsatisfactory, but a large, soft, smooth, tender mass was felt in the region of the prostate.

Further questioning brought out the fact that the patient at times had noticed a large mass appearing in the region of the cecum and travelling upward, then across and down to the left groin. This was accompanied by great pain, relieved as the mass disappeared.

Temperature, 98; pulse, 80; respiration, 20. The urine was negative, the Wasserman and Hinton negative. Urea, 13 mgm; sugar, 73 mgm. An X-ray of the lumbar spine and pelvis showed no evidence of metastatic malignant disease.

On April 13, a transverse colostomy was done. Following the operation, the pulse and temperature remained unchanged. The day following the temperature rose gradually to 103, the pulse to 120, the respiration to 40. There was moderate dyspnea and rales in the chest. The patient died on the second post-operative day.

##### DR. WILFRED PICKLES:

The operative findings are not recorded in the abstract but I think it fair to add them now.

Left rectus incision for Mixter colostomy made; small gut very distended; abdomen full of straw colored fluid; no definite mass felt at rectum, but areas of marked induration at recto-sigmoid junction. Root of mesentery full of hard shotty masses. Many hard white areas in small gut; omentum full of hard shotty masses. Piece taken for biopsy. Liver was smooth: sigmoid could not be brought up as it was embedded in mass of hard tissue. Loop of transverse colon brought to upper end of wound, with Paul tube and rubber tissue under it. Wound closed in layers. Postoperative Diagnosis: Generalized carcinomatosis, from rectal cancer.

It seems evident that it was felt that this man had a carcinoma of the rectum or sigmoid and apparently his condition did not warrant further study and a colostomy was done.

On the day of operation the patient was apparently well but the next day the temperature rose to 103°.

DR. EMERY M. PORTER:

I think the diagnosis is obvious from the operative findings, the glands, the omentum and the mass in the sigmoid. Before we were given that information I had noted some things to be ruled out. Carcinoma of the prostate, I think, is one thing to consider, but he comes in with no G. U. symptoms. Carcinoma of the rectum has to be considered, but it would have to be a very late stage to cause the obstruction which he had. The history of the mass on the right which comes up and goes across the abdomen rules out carcinoma of the stomach or anything higher up. No blood count is recorded but with normal temperature and pulse I think we can rule out a pyogenic thing. Actinomycosis has to be considered but it would not give him all the glands found at operation. Syphilis, I think, can be ruled out. Polyposis is possible from his history but you would expect more loss of weight and anemia. Same with T. B. and should have a temperature at examination. Polyp felt by rectum would not give that type of obstruction. Now an ulcerative colitis—but there again he would have diarrhea rather than obstruction. Diverticulitis would have to be considered but he has had no previous attacks. Lymphogranuloma inguinale certainly could give many of these signs and symptoms except it is usually low down and you can feel it. Adenomas and papillomas are rare. The possibility is in carcinoma of the rectum. I don't see anything else that could give that mass, and there are glands and something in the omentum—this certainly suggests a malignancy somewhere. A man of the right age and with increased constipation—I cannot say it is anything but a malignant growth of some sort. What the white plaques are in the small intestine I don't know.

DR. CHARLES GORMLY:

I would like to ask what the immediate cause of death was.

DR. PICKLES:

Pneumonia. There has been no proctoscopic examination — no rectal examination except an

unsatisfactory one. The proctoscopic examination would be very valuable and rule out some of these things.

#### POSTMORTEM FINDINGS

DR. B. EARL CLARKE:

When the peritoneal cavity was opened it was found that the entire small intestine was markedly dilated. At the junction of the caecum and ileum, extending out 10 cm. on the ileum and growing around the caecum was a large tumor mass which completely encircled the ileum and greatly reduced its lumen so that there was definite obstruction. There were, in addition to this large mass, implants on the peritoneum and particularly in the pelvis between the bladder and rectum was a large spherical implant. That was what was felt by rectum. This compressed and obstructed the rectum. There were two obstructions: one at the rectum and one at the ileum. Apart from these peritoneal implants there were no glandular metastasis. When the gut was opened there was no cancer involvement anywhere in the mucosa—either in the rectum or in the ileum or caecum. This was all external to the gut and apparently did not originate in the mucosa of the intestine.

When the large mass was sectioned there was found in it a structure without any lumen but its size and shape indicated it was the appendix. The histology of the tumor was a little bit confusing but it did not appear to be very malignant. So we concluded that this is a carcinoid of the appendix with somewhat more than the usual degree of malignancy. This tumor is rather rare but it is the common tumor in the appendix. During the last ten years we have had fifteen at this hospital and at the Presbyterian Hospital in New York they reported nine in a ten year period. Ordinarily they are small—they remain within the wall of the appendix. They invade the wall but rarely metastasize. They are considered relatively benign and they very seldom cause death. "In this case, while there are no metastases, the tumor has grown to unusual size and has extended to involve the peritoneal surfaces.

#### *Clinical Diagnosis:*

Carcinoma of the sigmoid, colon or upper rectum.

#### *Postmortem Diagnosis:*

Carcinoid of the appendix with peritoneal implants and obstruction of rectum and ileum.



### THE RHODE ISLAND MEDICAL JOURNAL

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### PREMARITAL EXAMINATION

While the laws governing premarital examinations are readily interpreted as they apply to residents of the state of origin, residents of other states have had difficulty in securing marriage licenses because of misunderstandings of the law by themselves or their examining physicians. At the request of the Commissioner of the Department of Health of the State of New York, we publish the following provisions of the New York law:—

The New York law provides that an application for a marriage license shall be accompanied by the statement of a licensed physician or commissioned medical officer, that such applicant has been given such examination, including a standard serological test, made in an approved laboratory, as may be necessary for the discovery of syphilis, made on a day specified in the statement, which shall not be more than the thirtieth day prior to that on which the application is made. The procedure in New York City differs from that in the rest of the state. The Commissioner of Health offers the following comments relative to the interpretation of the law:

Laboratory tests made as a part of premarital examinations for persons applying for marriage

licenses in New York state, outside of New York City, as well as the laboratories in which these tests are performed, must be approved by the New York State commissioner of health. For administrative reasons laboratories within New York State only have been approved for tests on applicants for licenses in the state exclusive of New York City.

The Commissioner of Health of the city of New York has approved certain out-of-state laboratories for the performance of serological tests on persons applying for marriage licenses in New York City. Requests for information concerning laboratories approved by the New York City Department of Health should be addressed to that department at Worth and Centre Streets, New York City.

*Outline of procedures for examination of out-of-state applicants for marriage licenses in New York State exclusive of New York City.*

1. Any physician duly licensed to practice medicine in the state in which he resides or in which he maintains his office may perform the necessary physical examination.

2. The specimen of blood must be sent to an approved laboratory in New York State. It is suggested that specimens be sent to the Division of Laboratories and Research, New York State Department of Health, New Scotland Avenue, Albany, N. Y., where examinations will be made free of charge.

3. The specimen should be labeled "for premarital examination."

4. The use of air mail is recommended when the specimen must be sent a great distance.

5. Upon completion of the test the laboratory will send the physician, in addition to the usual laboratory report, a certificate to the effect that the serological test was performed as a part of a premarital examination.

6. If, in the opinion of the examining physician the applicant is free from syphilis or does not have the disease in a stage which may become communicable, he should complete the certificate as indicated thereon.

7. The certificate is given to the applicant who will submit it to the clerk when the marriage license is applied for.

For further information relative to the marriage of persons in New York State, exclusive of New York City, communications should be addressed to the Division of Syphilis Control, New York State Department of Health, Albany, N. Y.

## WHY FLAMMABLE

Manufacturers of anesthetic gases provide placards on "Operating Room Precautions." "No Smoking: No Open Flames. No Live Caution. Flammable Anesthetics Being Used."

The word "flammable" is the antique, discarded form of the modern word "inflammable." To rejuvenate this obsolete word serves no purpose except to cloud the issue.

With the exception of some completely oxidized products, there are few materials which will not burn if subjected to a sufficient degree of heat. On the application of heat to combustible matter it unites with oxygen with production of more heat. Inflammable substances are such as are easily set on fire. Explosives unite with oxygen rapidly, with great expansion in volume, with force and a loud report. This classification is subject to modification. Kerosene, gasoline or alcohol, classified as inflammable, form with oxygen an explosive mixture which will propel an internal combustion engine. Some of the combustible materials, reduced to fine powder, become explosive. On the other hand, the reaction of explosives depends upon the proportion of available oxygen. Since the time of Priestley it has been known that explosions do not occur in a vacuum.

Of the anesthetic agents, while pure chloroform is not combustible, anesthetic chloroform, containing alcohol, burns with a smoky flame; conceivably it might become explosive. Ethyl chloride, igniting more readily, may be classified as inflammable. Ether and vinyl ether are inflammable. With a proper proportion of oxygen, their vapors form explosive mixtures. Acetylene burns in the hot oxy-acetylene flame but is handled with special precautions because of its explosive nature. While the ethylene in illuminating gas burns safely, pure ethylene mixed with oxygen is violently explosive. A mixture of cyclopropane and oxygen explodes with even greater violence.

In the operating room we are not specially interested in anesthetic gases and vapors as inflammable; common sense and ordinary precautions prevent operating room fires. Explosions are in a different category; they wreck the patient's lungs, the anesthetist's person, the anesthetic machine, the plate glass windows. Rather than demonstrations of inflammability we need further study of the nature, force and source of explosibility.

## RHODE ISLAND MEDICAL SOCIETY

## Minutes of the One Hundred and Twenty-eighth Annual Sessions

## Scientific Session

The one hundred and twenty-eighth Annual Meeting of the Rhode Island Medical Society was called to order by the President, Dr. Edward S. Brackett, at the Medical Library, on Wednesday, June 7, 1939, at 2:15 P. M. The President recognized delegates from state societies; Dr. George R. Campbell of Augusta, Maine; Dr. Perry of New Bedford, Massachusetts; Dr. Garcin of Danielson, Connecticut.

Dr. Wilfred Pickles reported for the Trustees of the Fiske Fund that they had made no award for the year 1939 and announced the subject chosen for the year 1940: "Fracture of the Femur, Results of Treatment Compiled from Experience or Hospital Records." The Committee on Necrology made no report.

The first paper was read by Dr. Marshall Fulton, Associate in Medicine at Harvard Medical School and Physician to the Peter Bent Brigham Hospital, on the subject "Aneurism and Rupture of the Ventricle of the Heart." He showed that these conditions occur as a result of coronary occlusion and follow coronary thrombosis in ninety per cent. of the cases.

The second paper, on "Ovum and Spermatozoan Age at the Time of Fertilization and the Course of Gestation and Development in Lower Animals," was read by Dr. William C. Young, Associate Professor of Biology at Brown University.

The third paper was read by Dr. Edgar Allen, Professor of Anatomy at Yale University School of Medicine, on the subject, "Evidence from Experiments with Ovarian Hormones in Monkeys and Applications to Conditions in Women."

Dr. Arthur T. Hertig, Pathologist to the Boston Lying-In Hospital and Free Hospital for Women, Brookline, read the final paper on this program. His subject was "Pathological Aspects of Spontaneous Abortion." The program was well balanced and proceeded without discussion.

After a buffet supper, served in the dining hall, the Society reassembled at 8:00 o'clock for the evening session. Dr. Elliott C. Cutler, Professor of Surgery at Harvard Medical School, addressed the

Society on the subject, "Selection of Patients for Surgery." His address is printed in this number of the JOURNAL.

Dr. Soma Weiss, Professor of Medicine at Harvard Medical School, then gave an address on "Circulatory Collapse and Shock." The address was of great practical value. Dr. Weiss defined syncope, shock and collapse but indicated that there is no sharp distinction in the classification. Syncope occurs in healthy, robust subjects, coming on suddenly, with a feeling of dizziness, with pallor and sweating. The blood pressure falls, especially the systolic pressure, giving a low pulse pressure. The pulse becomes imperceptible and the subject unconscious. Recovery commences as soon as the subject is placed in the horizontal posture. Shock is the collapse of a cardio-vascular system already disturbed. The pulse rate rises; the blood pressure is lowered. A low blood pressure is not so valuable a sign unless the pulse is rapid. Collapse differs from shock in the time element and in reversibility. In both conditions there is a disproportion between the vascular capacity and the blood volume. Only twenty or thirty percent. of the blood volume is working, an amount incompatible with the working of the central nervous system. The bulk of the blood is either parked or lost and less blood is returned to the right heart. Either shock or collapse may be warm or cold, depending on whether the peripheral arterioles are open or closed. Factors to consider in the prediction of shock are fear, the state of nutrition, age, sex—females are resistant—the presence of infection. Rest in bed for forty days is not favorable in prevention of shock. Valuable agents in treatment of shock are posture, strychnine, coramine and caffeine. Epinephrin and ephedrin are ineffectual.

On Thursday, June 8, the meeting was called to order at 2:00 P. M. Dr. Perrin H. Long, Associate Professor of Medicine at Johns Hopkins Medical School, read the first paper, with the subject, "The Clinical Use of Sulfapyridine in the Treatment of Pneumococcal Infections." Sulfapyridine does prevent proliferation of pneumococci. The patient must form his own antibodies. Dr. Long predicted a large decrease in the mortality rate from pneumonia in the next season. Objections to sulfapyridine are increase in nausea and vomiting, and formation of renal stones. Dr. Long's paper was discussed by Drs. Emery M. Porter and William S. Streker.

The second paper, on "Primary Carcinoma of the Lung," was read by Dr. Edward Delos Churchill, Professor of Surgery at Harvard Medical School. His exhaustive presentation of the subject was illustrated with lantern slides and motion pictures.

The third paper, on the subject, "Treatment of Carcinoma of the Cervix: Report on 135 Additional Cases, with Five Year Results," by Drs. Herman C. Pitts and George W. Waterman, was read by Dr. Waterman. It was a supplement to their paper of two years ago.

The fourth number on the program was a symposium on "Anesthesia for the Benefit of the Patient," by Drs. Albert H. Miller, Meyer Saklad, and John A. Hayward. Dr. Miller discussed Pre-medication; Dr. Saklad, Agents; and Dr. Hayward, Methods.

Dr. Brackett then delivered the Presidential Address, which has been printed in the July number of the JOURNAL, and finally inducted into office the officers for the ensuing year: Dr. Charles H. Holt, President; Dr. Lucius C. Kingman, First Vice-President; Dr. Frederic V. Hussey, Second Vice-President; Dr. Guy W. Wells, Secretary; Dr. Jesse E. Mowry, Treasurer.

The annual dinner was served at the Pomham Club at 7:00 P. M. Dr. Murray S. Danforth was Anniversary Chairman and Dr. Reginald Fitz, Professor of Medicine at Boston University, the speaker for this occasion.

Throughout the sessions the following Commercial Exhibits were displayed at the Medical Library:

Blanding & Blanding, Inc., Providence  
The Borden Company, New York  
Boss & Seiffert Company, Inc., Providence  
George L. Claffin Company, Providence  
Otis Clapp & Son, Inc., Providence  
The Coca-Cola Company, Atlanta, Georgia  
Davies, Rose & Company, Ltd., Boston  
Lederle Laboratories, Inc., New York  
Mead Johnson & Company, Evansville, Indiana  
Philip Morris & Co., Ltd., Inc., New York  
Smith, Kline & French Laboratories, Philadelphia

While the membership of the Society was mostly silent at the scientific sessions, local presentations at the morning clinics were notable for their interest and value. Wednesday morning, at the Charles V. Chapin Hospital, Drs. Hugh E. Kiene, Himon Miller, and Robert J. Streitwieser presented

"Metrazol Therapy at the Charles V. Chapin Hospital," a resume of which will be published in an early issue of the JOURNAL. Drs. Alex M. Burgess, Nat H. Gifford, John C. Ham, and J. Murray Beardsley presented "Modern Treatment of Tuberculosis with Special Reference to Collapse Therapy." Drs. Dennett L. Richardson, K. K. Gregory, and Edward J. West gave a clinic on "Acute Infectious Diseases."

At St. Joseph's Hospital the following topics were presented: Drs. William H. Jordan, Francis V. Corrigan, and Frank Jacobson. "Whooping Cough and Diphtheria Immunization," "Thymus Gland Enlargements and Consequences." Drs. Edward Burke, John Gormly and Agostino Sammartino, "Proper Standards of Prenatal Care. Discussion of Cases." Dr. Vincent J. Ryan, "Treatment of Common Skin Diseases." Drs. Vincent J. Oddo, John Streker, and Arthur E. Hardy, "Use of Sulfanilamide in G. U. Infections." Drs. William A. Horan, Thomas Murphy, and Walter Molony, "Results Obtained by Blind Nailing of Fractures of Neck of Femur." Dr. James A. Hamilton, "Value of Cardiographic Readings to the General Practitioner." Drs. William S. Streker, John T. Monahan, and Patrick I. O'Rourke, "Experiences with Sulfapyridine in the Treatment of Pneumonia." Dr. John C. Corrigan, "Case Presentation—Carotid Sinus Phenomenon in Diabetic Patient." Dr. Joseph L. Dowling, "The Care of Industrial Eye Injuries." Operative Clinics were held by the various surgical departments.

Thursday morning at the Miriam Hospital, operative clinics were given by Dr. Frank E. McEvoy and Staff of the Surgical Service and by Dr. H. Winkler of the Nose and Throat Service. Dry clinics were given by Dr. L. I. Kramer and Staff of the Medical Department, Drs. B. Sharp and H. Grossman of the Eye Service, Dr. B. Feinberg of the Pediatric Service. Dr. Ira Noyes and the Obstetrical Staff presented "The X-ray in Obstetrical Diagnosis." Dr. S. Kennison and Staff gave laboratory demonstrations.

Thursday morning the Rhode Island Hospital presented demonstrations in the Peters House, the Aldrich House, and in the main operating rooms. Subjects treated of at the Peters House were as follows: Dr. Eric Stone, "Treatment of G. C. with Sulfanilamide." Dr. H. K. Turner, "Renal Stone." Dr. H. E. Harris, "The Use of Nails in Fractures of the Neck of the Femur." Dr. Henry McCusker,

"The Use of Pins in Fractures of the Neck of the Femur." Dr. J. Murphy, "Hydatidiform Mole." Dr. B. H. Buxton, "Methods of Sterilization." Dr. J. A. McCann, "Treatment of Pelvic Hemorrhage." Dr. Joseph Franklin, "Report of a Case of Death Following Blood Transfusion." Dr. William Mahoney, "Thyroid Surgery." Dr. Charles Ashworth, "Appendicitis." Dr. Frank Littlefield, "Plastic Surgery." Dr. Robert Baldridge, "Surgery for Hyperthyroidism." Dr. Edward Cameron, "The Use of Radium in Our Clinic." Dr. Charles J. Smith, "A Dentist's Observations in the Tumor Clinic."

The following subjects were presented in the Aldrich House: Dr. Frank T. Fulton, "Are There Recognizable Warnings of Impending Coronary Thrombosis?" Dr. Cecil Dustin, "The Mechanism of Heart Pain." Drs. Buffum, Bates and Freedman, "Demonstration of Technique of Allergy Testing." Dr. Harold Calder, "Serum and Sulfapyridine in Treatment of Pneumonia." Dr. Charles Gormly, "Bronchiectasis." Dr. E. Windsberg, "Rare Operative Case." Dr. L. S. Happ, "Bronchoscopic Carcinoma." Dr. Morgan Cutts, "Sulfapyridine in Treatment of Pneumonia." Dr. Paul Cook, "Luetic Aneurism with Intercurrent Heart Block." "Cheyne-Stokes Respiration." "Multiple Lobar Pneumonia." "Myelogenous Leukemia." Dr. Herman A. Lawson, "Multiple Bone Changes with Atypical Blood Picture." Dr. W. N. Hughes, "Multiple Sclerosis." "Differential Diagnosis Between Meniere's Disease and Acoustic Neuroma."

Respectfully submitted,

ALBERT H. MILLER, M.D., *Secretary pro-tem.*

#### Report of the Entertainment Committee

After considering numerous possible places for holding the Annual Dinner, your committee feels that from the standpoint of accessibility, pleasant surroundings, and excellence of the food which is served, the Pomham Club is a desirable place for holding the Dinner.

The serving of a Supper on Wednesday evening, June 7th at the Medical Library Building, has been arranged with the usual Caterer.

Respectfully submitted,

FRANK W. DIMMITT, M.D.,  
*Chairman.*

**PROVIDENCE MEDICAL ASSOCIATION****Minutes of the June Meeting**

A regular meeting of the Providence Medical Association was held at the Medical Library on Monday, June 5, 1939. In the absence of Dr. Messinger, the meeting was called to order by Dr. John G. Walsh, Vice-President of the Association, at 8:35 P. M. The minutes of the preceding meeting were read by the Secretary and upon motion of Dr. A. M. Burgess were accepted as read.

The Secretary reported for the Standing Committee as follows:

1. That the Executive Secretary had been authorized to serve as an official representative of the Association on the Council of Social Agencies of Providence.
2. That a motion had been passed that a resolution relative to the Wagner National Health Act be prepared and submitted to the Association with recommendation of adoption, and that if adopted copies be sent to the members of Congress from Rhode Island.
3. That a motion had been passed requesting the President to appoint a Committee on Credit and Collection for the purpose of studying that question for the Association.
4. That a recommendation had been passed that the officers of the Providence Medical Association voluntarily associate with the officers of the State Medical Society in an effort to work out a suitable plan relative to increasing the membership of the State Medical Society.
5. That a motion had been passed that the proposed amendments to the Constitution and By-Laws of the Association be adopted and that, if adopted, a copy of the revised Constitution and By-Laws be sent to each member of the Association during the summer.
6. That a motion had been passed authorizing the Executive Secretary to send during the summer to each member of the Association, a copy of the revised Constitution and By-Laws, if adopted, copies of any special committee reports not printed in the RHODE ISLAND MEDICAL JOURNAL, and whatever other forms may be necessary for the better operation of the Association and the executive office.
7. That a motion had been passed that the final report of the Committee for the Study of the Need

and Supply of Medical Care in the district, as prepared for the American Medical Association, be mimeographed and distributed to all the agencies aiding in the survey, and also sent to the members of Congress from Rhode Island. The report of the Standing Committee was accepted as presented.

Dr. Walsh reported that the obituary of Dr. Clifford B. Colwell, prepared by Dr. Alvah H. Barnes and Dr. Edward F. Burke, was on file with the Secretary.

Dr. Alex M. Burgess, Chairman, reported for the Committee on the Study of Voluntary Health Insurance and submitted as part of his report a tentative plan for such insurance under the auspices of this Association. Dr. Eric Stone moved that the report be accepted as read and that a copy of the proposed plan, together with the report, be sent to each member of the Association that all may be thoroughly familiar with the plan for discussion at a future regular meeting. The motion was seconded by Dr. Robert G. Murphy and was passed unanimously.

Dr. Walter S. Jones presented the report of the Committee on the Study of Telephone Service, which was accepted as read.

Dr. Philip Batchelder made a further report of progress for the Committee on Tuberculosis, which included recommendations for further action by the Association. Dr. E. M. Porter moved the acceptance of the report and its recommendations. The motion was seconded and passed.

Dr. Robert G. Murphy read the report of the Committee for the Study of Group Health and Accident Insurance. The report was accepted as presented.

The Secretary reported for the Committee on Revision of the Constitution and By-Laws, and outlined the proposed revisions. By a unanimous vote the amendments and revisions to the Constitution and the By-Laws were adopted.

The Secretary reported that the Standing Committee recommended the election to membership in the Association of Irving A. Beck, M.D., and James P. Deery, M.D. The motion of Dr. William Muncy that these applicants be elected to membership was seconded, and by a unanimous vote the men were declared elected.

Dr. Walsh announced that the annual golf tournament and dinner of the Association would be held at the Wannamoisett Country Club on Wednesday, June 21.

Dr. Walsh announced that the President had made the following committee appointments: Committee on Credit and Collection: Dr. J. Edwards Kerney, Chairman, Dr. Benedict Chapas, Dr. G. Raymond Fox, Dr. Angelo Scorpio, Dr. John S. Dziob. Advisory Committee to the Rhode Island State Home and School: Dr. Harold G. Calder and Dr. Charles Bradley.

Dr. William P. Buffum spoke briefly on the plans for the active participation of the membership in the Community Fund Drive in the fall, and called for full cooperation from every physician and also from the dentists.

Dr. Charles F. Gormly presented the following resolution relative to the Wagner National Health Act:

Whereas, the Wagner National Health Act presented to Congress has been studied and opposed by the House of Delegates of the American Medical Association because

It does not safeguard in any way the continued existence of the private practitioners,

It fails to provide for the use of the thousands of vacant beds now available in hundreds of general hospitals,

It proposes to make Federal aid for medical care the rule rather than the exception,

It does not recognize the need for suitable food, sanitary housing, and the improvement of other environmental conditions necessary to the continuous prevention of disease,

It proposes complete medical service in addition to compensation for loss of wages during illness,

It gives authority to Federal agents to disapprove plans proposed by the States, and

Whereas, Federal subsidies have invariably involved Federal control,

Therefore, the Providence Medical Association opposes this proposed legislation as inimical to the best interests of the health of the people of this country and to the medical profession, which is entrusted with the protection of that health, and

This Association recommends that any state in actual need, for prevention of disease, for promotion of health, or for care of the sick should be able to obtain aid in a medical emergency without stimulating every other state to seek and to accept similar aid, thus to have imposed upon it the burden of Federal control.

The resolution was endorsed by a voice vote of the membership.

The President introduced as the speaker of the evening, Dr. Raymond L. Webster of the Orthodontic Staff of the Samuels Dental Clinic of Rhode Island Hospital and Vice-President of the Rhode Island Dental Society. Dr. Webster responded with a discussion of "Dental Problems of Interest to the Medical Man." Discussion was offered by Drs. Henry Utter, William Muncy, and Harold Williams of the Providence Medical Association, and by Dr. Charles Smith and Dr. Edward C. Morin for the State Dental Society.

The meeting was adjourned at 10:30 P. M. Attendance, 105. Collation was served.

Respectfully submitted,

HERMAN A. LAWSON, M.D., *Secretary*

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#### LOCAL EVENTS

The Annual Outing of the Staff of St. Joseph's Hospital was held at the Metacomet Golf Club on Wednesday, June 14. Frank Wardell, Explorer and Traveller, gave an account of life in Africa and the Far East, illustrated with motion picture films.

The Providence Medical Association held its Annual Golf Tournament at the Wannamoisett Country Club on Wednesday, June 21.

The Rhode Island Medico-Legal Society held its Annual Meeting and Election of Officers at Tophill Restaurant on Thursday, June 29.

Dr. Roland Hammond was the recipient of an Honorary Master of Arts degree conferred by Tufts College on June 19.

Dr. H. Frederick Stephens is associated with Dr. George W. VanBenschoten in the Practice of Ophthalmology.

Dr. Kenneth G. Burton is limiting his practice to Fractures and Orthopedic Surgery.

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#### RHODE ISLAND HOSPITAL

On July 1, August Henry Clagett, Jr., M.D., of Philadelphia, became Resident Cardiologist. Pre-medical education was obtained from the University of Pennsylvania and his M.D. from Hahnemann Medical College. He was in General Practice in Milton, Delaware, for one year, and did post-graduate work in Internal Medicine for one year at the Graduate School of Medicine, University of Pennsylvania. Dr. Clagett is married.

On July 1, Dr. John R. Ross, of Bellevue, Ohio, began a year's internship in Pathology. Dr. Ross is a graduate of Ohio State University and Medical School. During his medical school years he had an internship for two summers at St. Elizabeth's Hospital in Youngstown, Ohio. Dr. Ross obtained an M.A. degree in Pathology from the University of Ohio.

On July 1, Dr. Harry Campbell took up residency at the Pondville Hospital, in Wrentham, Mass. Dr. Campbell recently visited at the Rhode Island Hospital.

Dr. Carl S. Sawyer, a graduate of Brown University and McGill Medical School, on July 15, started a two year's internship. Dr. Sawyer is a son of Dr. Carl D. Sawyer.

Dr. Henry Miller, recent cardiologist, is now taking a service at Pratt's Diagnostic Hospital, Boston.

Dr. Charles Bryan's internship terminated June 30. He is now taking a year in Pathology at the New England Deaconess Hospital in Boston.

Dr. Herman I. Riddell, of Los Angeles, California, a graduate of the University of California in Los Angeles, 1933, and the University of Southern California, where he obtained his M.D. degree in 1936, started a year's internship in Pathology on June 29. From 1936 to 1939, Dr. Riddell did Surgery at the Louisville City Hospital, Louisville, Kentucky. Dr. Riddell is married.

Dr. Howard M. Trafton, of Brookline, Massachusetts, a graduate of Bates College and Boston University Medical School, on July 1st, began a two year's internship.

On July 15, Dr. Morris Goldenberg, of Los Angeles, California, became Anaesthesia Resident. Dr. Goldenberg took his pre-medical course at M. I. T. in Boston and obtained his M.D. from Tufts Medical School in 1936. He interned at the Cedars of Lebanon Hospital in Los Angeles, a one year's rotating service. He also had a substitute residency in Obstetrics and Gynecology at the Boston City Hospital. Dr. Goldenberg is married.

On July 1, Dr. Scott L. Tarplee became Resident Physician at the Jane Brown Memorial Hospital. Dr. Tarplee's home is in Atlanta, Georgia. He graduated from Emory College and Medical School. He interned for one year at the Grady Hospital in Atlanta and one year at the Massachusetts Memorial Hospital in Medicine on the service of Dr. Fitz.

Dr. Leo Francis Geoghegan, of Providence, Providence College and Tufts' Dental School, began a fifteen months Dental Internship, on July 1.

On July 24, to Dr. and Mrs. Reginald C. Farrow, a son, John Tyler Farrow. Dr. Farrow resides at 106 Clarendon Street, Syracuse, N. Y.

On July 30, at the Lying-In Hospital in Providence, to Dr. F. Woodward Lewis and Dr. Elizabeth Lewis, a son, F. Woodward Lewis, Jr. Dr. F. Woodward Lewis began an Internship at the Lying-In Hospital on August 1.

Dr. Reeves Betts is at present a patient at the Palmer Hospital, Boston, Massachusetts, having been operated on for appendicitis.

Dr. Richard Bruning of Maplewood, New Jersey and Dr. Robert Richards of Pondville Hospital, Wrentham, Massachusetts, visited the Rhode Island Hospital recently.

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#### RECENT BOOKS

PRACTICE OF ALLERGY. By Warren T. Vaughan, M.D., pp. 1082, illustrations, 338, Cloth, \$11.50, The C. V. Mosby Company, 3525 Pine Boulevard, St. Louis, 1939.

Dr. Vaughan has written a very complete text book covering the present knowledge in the field of clinical allergy. The theoretical part, dealing with the physiology and immunology of the allergic response is short. He describes with great detail his technic in diagnosis and treatment. He also discusses at length with many illustrative cases inhalant, food, and contact allergy; and interesting observations are made about possible allergic influences in diseases not usually classified as allergic in nature.

Altogether this is a fine work, detailed enough to be useful for reference, and probably the best text book at present available.

WILLIAM P. BUFFUM, M.D.

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MEDICOLEGAL PHASES OF OCCUPATIONAL DISEASES, by C. O. Sappington, M.D., Dr.P.H. pp., 400, \$2.75. Industrial Health Book Company, Chicago, 1939.

Every physician in general practice today is coming more and more into contact with occupational diseases, because of the emphasis being placed on such diseases through legislation. It is becoming necessary that the general practitioner have knowledge of at least the fundamental principles of industrial medicine, industrial hygiene, and occupational diseases, so that he may properly evaluate the etiologic factors of actual or alleged occupational diseases which may come to his attention. He will find this volume of inestimable value in this respect.